NOTICE OF DEATH FORM

DIDD-0483 Revised 7/15

Within 4 hours of the discovery of a death that is or may be a Suspicious, Unexpected, or Unexplained Death, the entity responsible for reporting the death shall report it to the DIDD Investigator. Also, **within 4 hours** of the discovery of any death, the primary provider must notify the DIDD Regional Office Administrator of the Day or, if applicable, the DIDD ICF/ID Director or Chief Officer or designee by telephone. A completed **Notice of Death Form** must be sent **within 1 business day** after discovery of the death. If a waiver provider or private ICF/IID, send it to the DIDD Regional Director. If a developmental center, send it to the DIDD Facilities Administrator and to the Deputy Commissioner.

East DIDD Regional Director		**Middle DIDD Regional Director**		**West DIDD Regional Director**	
Phone #	(865) 588-0508	Phone #	(615) 231-5436	Phone #	(901) 745-7361
Fax #	(865) 558-0226	Fax #	(615) 231-5350	Fax #	(901) 745-7251
Crisis Pager	(855) 828-4717	Crisis Pager	(615) 218-0784	Crisis Pager	(866) 925-4204

PERSON SUPPORTED INFORMATION

DIDD REGION: [ ] East [ ] Middle [ ] West

NAME: _____ **DATE OF BIRTH**: _____

SOCIAL SECURITY NO: _____ **AGE AT DEATH**: _____

RACE: [ ] White [ ] Black [ ] Hispanic [ ] Other **SEX**: [ ] Male [ ] Female

CLASS MEMBER STATUS: [ ] Settlement Agreement [ ] Not applicable

FUNDING STATUS [ ] "Statewide" Waiver [ ] "Self-Determination" Waiver [ ] Private ICF/ID

[ ] CAC Waiver [ ] State-Funded [ ] Developmental Center [ ] State ICF/ID

RESIDENCE

[ ] Lived with family [ ] Supportive Living [ ] Private ICF/ID

[ ] Lived in Own Home with Support [ ] Residential Habilitation [ ] Developmental Center

[ ] Lived Independently [ ] Medical Residential Services [ ] Nursing Facility

[ ] Family Model Residential Services [ ] Other (explain) _____

DID THE PERSON SERVED MOVE IN THE PAST 6 MONTHS? [ ] No [ ] Yes (specify date: _____)

DATE OF DEATH: _____ **DATE REPORTED**: _____ **TIME REPORTED**: _____ AM / PM

PLACE OF DEATH [ ] Home [ ] Psychiatric Facility

[ ] Hospital [ ] Other (explain) _____

DETAILS OF DEATH _____

1. AUTOPSY REQUESTED? [ ] No [ ] Yes, If so, by whom _____

2. MEDICAL EXAMINER CONTACTED? [ ] No [ ] Yes, If so, by whom _____

3. CORONER CONTACTED? [ ] No [ ] Yes, If so, by whom _____

4. INCIDENT FORM SUBMITTED? [ ] No [ ] Yes

INDICATE WHO HAS BEEN NOTIFIED

[ ] ISC/Case Manager [ ] Legal Representative [ ] Family [ ] DIDD Investigator [ ] Police

NAME OF PRIMARY CARE PROVIDER: _____ **PHONE NO**: _____

TYPE OF CASE MANAGER [ ] ISC [ ] State Case Manager [ ] QMRP

NAME OF CASE MANAGER: _____ **PHONE NO**: _____

NAME OF ISC AGENCY: _____ **PHONE NO**: _____

NEXT OF KIN and/or **LEGAL REPRESENTATIVE**: _____

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GENERAL HEALTHCARE INFORMATION

NAME OF PERSON SUPPORTED: _____

AMBULATION: [ ] Ambulatory [ ] Non-Ambulatory

COMMUNICATION: [ ] Verbal [ ] Non-verbal

NUTRITION: [ ] Eats Independently [ ] Eats w/ Assistance [ ] Tube fed

WEIGHT IS: [ ] Normal Weight [ ] Overweight [ ] Underweight

WEIGHT: _____
HEIGHT: _____

PHYSICAL STATUS REVIEW (if applicable) **DATE OF LAST PSR:** _____ **PSR LEVEL:** _____

MEDICATIONS: _____

INTELLECTUAL DISABILITY [ ] Mild [ ] Moderate [ ] Severe [ ] Profound [ ] Unknown / Unspecified

Etiology (if known): _____

BEHAVIORAL / PSYCHIATRIC DIAGNOSES: _____

GENERAL MEDIACAL DIAGNOSES: _____

HOSPITALIZATIONS / PROCEDURES (over the past 12 months)

Reason for Hospitalization / Procedure:	Treatment Location:	Date:

Name of Provider, Private ICF/IID, or DIDD Developmental Center **Phone Number**

Person Completing this Form (please print) **Title**

Signature **Date**

TN Department of Intellectual & Developmental Disabilities